



Construction Contractor Services

1501 Belcher Rd. S., Ste B5, Largo, FL 33771
 5121 Ehrlich Road, Suite 108, Tampa, FL 33624
 260 Maitland Ave., Suite 1650, Altamonte Springs, FL 32701
 1743 E. Main St., Ste. 118, Plainfield, IN 46168

For Office Use Only:
 \$

Personal Info		TRADE:	
Name:	Driver's License #:		
Address:	Vehicle Make:	Model:	
City, State, Zip	Color:	Year:	
Home Ph:	Cell Ph:		
Emergency Ph:	Email:		

Former Employers					
Date	Name of Employer	Phone	Position	Pay Rate	Reason For Leaving
From					
To					
From					
To					
From					
To					

Trade Schools		
School	Study	Year Graduated
School	Study	Year Graduated

Experience		Wage Range Expected:			
Years	Trade	Years	Trade	Years	Trade
CARPENTRY		MECHANICAL		MASONRY	
_____	Wood Frame	_____	Electrician	_____	Block
_____	Concrete Form	_____	Res Comm New Serv	_____	Brick
_____	Trim	_____	HVAC	_____	Concrete Pour
_____	Metal Stud	_____	board sheet mtl	_____	Concrete Finish
_____	Drywall Hang	_____	install changeouts	_____	Tile
_____	Drywall Flnish	_____	Plumber	REMODEL Specify below	
_____	Paint Int Ext	_____	Res Comm New Serv		
		_____	Welding cert to_____		

Other

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

DISCLOSURE AND ACKNOWLEDGMENT (IMPORTANT - PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT)

Construction Contractor Services, Inc., may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer Report" and/or an "investigative" consumer report which may include information about your character, general reputation, personal characteristics, and/or mode of living, which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may include employment history and reference checks, criminal and civil litigation history information, motor vehicle records (driving records), sex offender status, credit reports, education verification, professional licenser drug testing, Social Security Verification, and information concerning workers' compensation claims (only after conditional offer of employment has been made.) Credit history will only be requested where as such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right upon written request made within a reasonable time after receipt of this notice, to request whether a consumer report has been run about you, and the nature and scope of any investigative consumer report, and request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Construction Contractor Services, Inc. and/or an outside organization. The scope of this notice and authorization, all-encompassing, however, allows Construction Contractor Services, Inc. to obtain from any outside organization, all manner of consumer reports and investigative consumer reports now and if you are hired throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and a Summary of YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and if I am hired throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state, or requested by Construction Contractor Services, Inc. and/or another outside organization acting on behalf of Construction Contractor Services, Inc. I agree that a facsimile ("fax"), electronic or photocopy of this Authorization shall be considered valid.

ACKNOWLEDGMENT AND AUTHORIZATION

California applicants or employees only: By signing below, you also acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the company.

Minnesota and Oklahoma applicants or employees only: Check this box if you would like to receive a free copy of a consumer report if one is obtained by the Company.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. You may also contact the Company to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated inquiries, which the Company shall provide within 5 days. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington State Fair Credit Reporting Act.

Signature Employee/Prospective Employee _____ Date _____

Name _____ Social Security # _____

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ▶ **Give Form W-4 to your employer.**
 ▶ **Your withholding is subject to review by the IRS.**

2022

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . ▶

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____ Multiply the number of other dependents by \$500 ▶ \$ _____ Add the amounts above and enter the total here 3 \$ _____		
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ ▶ _____
Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
-----------------------	-----------------------------	--------------------------	--------------------------------------



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address			Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)		
Last Name (Family Name)		First Name (Given Name)		
Address (Street Number and Name)		City or Town	State	ZIP Code

Employer Completes Next Page



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
-------------------------------------	-------------------------	-------------------------	------	--------------------------------

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		<div style="border: 1px solid black; padding: 5px;">Additional Information</div>		<div style="border: 1px solid black; padding: 5px; text-align: center;">QR Code - Sections 2 & 3 Do Not Write In This Space</div>
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
--	---------------------------	---

CO-EMPLOYMENT NOTICE AND ACKNOWLEDGMENT



MUST BE COMPLETED BY WORKSITE EMPLOYER

Worksite Employer: _____ Employee ID#: _____

Department: _____ Worksite Location: _____ Title: _____ WC Code: _____

Hire Date: _____ PEO Hire Date: _____ First Date Worked: _____ First Check Date: _____

Pay Rate: _____ Pay Frequency: _____ Weekly _____ Bi-Weekly _____ Semi-Monthly _____ Monthly

Pay Type: _____ Hourly _____ Salary Exempt _____ Salary Non-exempt _____ Commission _____ Other

Employment Status: _____ Full-Time _____ Part-Time _____ Temporary _____ Seasonal _____ On-Call

Authorized Signature: _____ Date: _____

EMPLOYEE INFORMATION

Name: _____
Last First Middle

Social Security Number: _____ E-Mail Address: _____

Address: _____ Apt. No. _____

City, State, Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Emergency Contact: _____ Relationship: _____
First and Last Name i.e. Spouse, Parent, Child

Daytime Phone Number: _____ Evening Phone Number: _____

Co-Employment. Your Worksite Employer and Trion Solutions, Inc. or one of its affiliates ("Trion") have entered into a Professional Employer Services Agreement (the "Agreement") that creates a co-employment relationship between your Worksite Employer, Trion and you by assigning certain human resource related functions to Trion. This is an ongoing relationship rather than a temporary or project-specific one, wherein the rights, duties and obligations of the employment relationship have been allocated between Trion and your Worksite Employer. Your Worksite Employer retains direction and control over your duties as is necessary to conduct its business and comply with licensing and regulatory laws. Trion, as the administrative co-employer, assumes responsibility for the payment of your wages, payroll taxes and benefits provided by the Worksite Employer, and reserves the right, along with your Worksite Employer, to hire, terminate, discipline and enforce employment and safety policies. The Worksite Employer is solely responsible for compliance with all federal, state and local laws regarding employment, including, but not limited to, discrimination and wage and hour laws and regulations.

Arbitration and Limitation Period. I agree that any dispute regarding my employment with the Worksite Employer, Trion and their shareholders, directors, officers or employees will be submitted and resolved by binding arbitration before the American Arbitration Association ("AAA") in accordance with its Employment Arbitration Rules and Mediation Procedures. The arbitrator may award attorney's fees to the prevailing party and all costs and expenses of the arbitration shall be allocated among the parties according to the arbitrator's discretion. The parties shall be entitled to discovery in accordance with the Federal Rules of Civil Procedure and the arbitrator's award may be entered as a final judgment in any court having jurisdiction and enforced in accordance with the arbitration award. Any claims for workers' compensation, unemployment benefits, welfare and pension benefits or claims under Section 7 of the National Labor Relations Act are excluded from this provision. I agree not to file any claim or suit relating to my employment with the Worksite Employer or Trion more than 182 calendar days after the event, practice or action complained of, and agree to waive any state or federal statutes of limitation to the contrary.

South Carolina Employees: Trion is a regulated PEO pursuant to the State's statutes and regulations. If you have any questions or complaints regarding this relationship you may contact:

Carolina Department of Consumer Affairs, 2221 Devine Street, Suite 200, Columbia, South Carolina, 29205. (803) 734-4200. www.consumer.sc.gov.

Employee Signature

Date: _____



**ELECTRONIC PAY
AUTHORIZATION FORM**

EMPLOYEE INFORMATION SECTION (* These are required fields to enroll in direct deposit)

*Employee Name	
*Client Name CCS FLORIDA 02-161	*Social Security Number
*Date of Birth	*Primary Phone Number (with area code)
*Address	*City
*State	*Zip Code
E-Mail Address	Employee System ID (Trion Solutions Use Only)

<p>Check one:</p> <p><input type="checkbox"/> Add my bank account(s) Employees may choose to deposit amounts in up to four different accounts below.</p> <p><input type="checkbox"/> Change my bank account(s) Please allow 2 pay periods for processing changes.</p> <p><input type="checkbox"/> Cancel all account(s) This will cancel all electronic deposits and a paper check will be issued. Allow 48 hours for cancellations.</p> <p><input type="checkbox"/> Issue me a Brinks Skylight Pay-card Everyone is eligible.</p>	<p>By signing below, I authorize Trion Solutions, Inc. and the financial institution(s) listed below to deposit my paycheck automatically and when necessary, to facilitate debit entries for funds erroneously deposited. I also understand that my request(s) related to direct deposit may take two to three pay periods to activate. This authorization supersedes any previous payroll deduction distribution form and will remain in effect until I can cancel in writing. I understand that all direct deposits are made through the Automated Clearing House (ACH), that the funds' availability is subject to the term and limitations of the ACH as well as my financial institution, and that the ACH process can take 48 hours to complete, excluding weekends and holidays. If electing the Pay-card option, a Welcome Kit will be sent to me detailing all of the benefits, terms and conditions. There is no approval or application process. FAILURE TO NOTIFY TRION SOLUTIONS OF A CLOSED ACCOUNT WILL RESULT IN A \$20.00 PROCESSING FEE.</p>
---	---

	*Nine Digit Routing Number	*Account Number	*Check	*Example: \$100.00 or 100%
1			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> Amount <input type="checkbox"/> Percentage
2			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> Amount <input type="checkbox"/> Percentage
3			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> Amount <input type="checkbox"/> Percentage
4			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> Amount <input type="checkbox"/> Percentage

Pay-Card				
	*Nine Digit Routing Number	*Account Number	*Check	*Example: \$100.00 or 100%
1	264171241		<input type="checkbox"/> Checking	<input type="checkbox"/> Amount <input type="checkbox"/> Percentage

Attach a copy of a VOID check, or a letter from your financial institution confirming the account and routing numbers to process a Direct Deposit.

Signature _____

Date _____

Employee Data Sheet

Employee General Information

Emergency Contact

Name: _____

Relationship: _____

Address: _____

Phone Number: _____

Post-hire Medical Questionnaire

Do you have any medical restrictions? ____ Yes ____ No

If yes, please explain: _____

Have you ever sustained an on the job injury or Workers' Compensation claim? ____ Yes ____ No

If Yes, When (Month/Year): _____ Part of body injured? _____

Employee Background Information

Have you ever been convicted of a felony? ____ Yes ____ No

If yes, please explain: _____

Equal Employment Opportunity

Check one (optional): Caucasian Hispanic or Latino African American American Indian Alaska Native
 Asian/Pacific Islander Other: _____

Gender: Male Female

Acknowledgements (please initial each line)

_____ I understand that my employment relationship is "at will" and not an employee contract.

_____ I understand that if my assignment ends I am required to contact CCS within two business days for possible reassignment. Failure to do so or failure to accept my next job assignment will indicate that I have voluntarily quit and may make me ineligible for unemployment benefits.

_____ I agree to abide by all CCS workplace policies and rules.

_____ I understand that any workplace injury must be reported immediately to my supervisor. Failure to do so can result in partial or full loss of worker's compensation benefits and disciplinary action up to and including termination.

_____ I understand that in the event of an injury I must choose a physician from the approved providers.

_____ I understand that a post-accident drug screen is mandatory. Failure to do so can result in partial or full loss of workers' compensation benefits and disciplinary action up to and including termination.

_____ I understand that my employer has a strict drug and alcohol policy and I may be subject to testing.

_____ I understand that I can report any witnessed workers' comp fraud and may obtain a reward.

I hereby certify that the above information is true and correct:

Employee Signature

Date



PROJECT SAFETY REQUIREMENTS

The personal safety and health of all workers is of primary importance to our organization. The prevention of occupationally induced injuries and illnesses is of such consequence that it will be given precedence over operating productivity whenever necessary. The following safety rules shall apply.

1. Report any unsafe condition to the project superintendent or your foreman immediately.
2. Obey all Safety and warning signs.
3. Proper attire shall be worn, including long pants (no shorts or sweat pants), and a shirt with a minimum of four inch sleeves.
4. Hard hats and safety glasses are required 100% of the time while on any and all construction jobsites.
5. A full face shield shall be worn by any employee whose task requires him to cut, grind, saw, burn or weld.
6. Fall protection systems shall be worn in accordance to OSHA Standard 1926.501(2)(3) or a pre-approved safety plan specific to the scope of work.
7. All other forms of PPE including, but not limited to safety glasses, goggles, side shields, hard hats, lanyards, etc. necessary to perform the work safely must be maintained in good condition.
8. Hand tools and small power tools must be kept in good repair and used only for the intended use. Tools that have frayed or damaged cords should be removed from service.
9. Good general housekeeping shall be maintained at all times. Work areas shall be kept free of debris, especially in aisles, walkways, in the vicinity of ladders, ramps, stairs, machinery and tools. Lay down areas shall be kept clean and neatly stockpiled for ease of access.
10. Empty containers, papers, or debris of any kind should be not allowed to accumulate in areas used by personnel on the jobsite.
11. All work place injuries/incidents must be reported immediately to your supervisor.
12. All work place injuries/incidents must be reported to CCS within 24 hours. This policy will be strictly enforced. A drug screen will be required.
13. Intoxicating beverages, drugs, and firearms are not to be brought onto the jobsite.
14. Anyone found intoxicated on any jobsite will be escorted off the property and reported.
15. All personnel are required to comply with OSHA rules and regulations at all times.

Printed Name

Signature

Date

Our company participates in the Work Opportunity Tax Credit Program. Your responses to the following questions will be confidential and used only to assist us in complying with the requirements of this program. Your answers will not affect your employment or any benefits you may be receiving. Thank you for your cooperation!

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

SS#: _____ Date of Birth: _____

Position: _____ Wage: \$ _____ Hire Date: _____

Please read each statement and Check "YES" to any statement that applies:

#	QUESTION	YES	NO
1	Have you worked for this employer before?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you , or any immediate member of your family, EVER received Temporary Assistance to Needy Families (TANF, Welfare)?	<input type="checkbox"/>	<input type="checkbox"/>
3	Have you , or any immediate member member of your family, received Supplemental Nutrition Assistance Program (SNAP) benefits (FOOD STAMPS) ANYTIME over the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
4	Have you been UNEMPLOYED the last 6 months and at ANYTIME received unemployment compensation?	<input type="checkbox"/>	<input type="checkbox"/>
5	I personally received Supplemental Security Income (SSI) or (SSDI) Supplemental Security Disability Income ANYTIME during the last 2 months	<input type="checkbox"/>	<input type="checkbox"/>
6	I participated in a rehab program approved by the state, the Ticket to Work program, or the Department of Veterans Affairs.	<input type="checkbox"/>	<input type="checkbox"/>
7	I am a VETERAN of the United States Armed Forces. IF "NO" SKIP TO #13	<input type="checkbox"/>	<input type="checkbox"/>
8	I am a VETERAN who received Supplemental Nutrition Assistance Program (SNAP) benefits (FOOD STAMPS) ANYTIME over the last 6 months.	<input type="checkbox"/>	<input type="checkbox"/>
9	I am a VETERAN who was UNEMPLOYED for more than 4 weeks, but less than 6 months, during the past year.	<input type="checkbox"/>	<input type="checkbox"/>
10	I am a VETERAN who was UNEMPLOYED for more than 6 months during the past year.	<input type="checkbox"/>	<input type="checkbox"/>
11	I am a VETERAN discharged from active duty within the last 12 months and entitled to compensation for a service connected disability.	<input type="checkbox"/>	<input type="checkbox"/>
12	I am a VETERAN receiving compensation for a service connected disability who was unemployed for at least 6 months during the last 12 months.	<input type="checkbox"/>	<input type="checkbox"/>
13	During LAST 12 MONTHS , I was convicted of a felony or released from prison for a felony.	<input type="checkbox"/>	<input type="checkbox"/>

I agree that I am voluntarily providing the information on this form and it is not a condition of employment my signature authorizes release of information to Department of Veterans Affairs, Department of Health and Human Services, Social Security Administration, and other Federal state, and local governments agencies to release information to client., to verify my eligibility for WOTC. I authorize this form to assist in completion of IRS Form 8850 and ETA Form 9061. Under penalties of perjury, I declare I provided the information on this form on or before the day a job was offered and that the information I have furnished is, to the best of my knowledge, true, correct, and complete.

Signature: _____ Date: _____